1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9189 **CERTIFICATE OF DEATH**

09182

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 77 RALPH ST.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 77 RALPH
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First EFFIE — Middle MAY — Last BARBER

4. DATE OF DEATH: Month 9 — Day 28 — Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-10-1889

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LEONARD FRIZZELL

14. MOTHER'S MAIDEN NAME: ALICE CARR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-16-1577

17. INFORMANT: LEWIS M. BARBER — Address: 77 Ralph St. WESTMINSTER, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9-25-56
DUE TO (b): Cardio-vascular-renal disease — 9-24-56
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442 X
DUE TO (c): with Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity for some years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): no

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-24, 1956 to 9-28, 1956 that I last saw the deceased alive on 9-28, 1956, and that death occurred at 2.30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. W. C. Billingslea M.D. — ADDRESS (Street, city or town, state): Westminster, md — DATE SIGNED

PHYSICIAN'S NAME (Type): C. H. Billingslea — Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-2-1956

22c. NAME OF CEMETERY OR CREMATORY: DEER PARK CEMETERY

22d. LOCATION (City, town, or county) (State): SMALLWOOD MD.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Bankard Son — ADDRESS: WESTMINSTER, MD.

24a. REC'D BY REGISTRAR DATE: 10-2-56

24b. REGISTRAR'S SIGNATURE: Hazel Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09183

9194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
c. LENGTH OF STAY IN 1b 5-yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) —

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: BENEDICT Middle: Last: BAUBLITZ

4. DATE OF DEATH Month: Sept Day: 25 Year: 1956

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Unknown

9. AGE (In years last birthday) about 78 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Laborer

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. —

17. INFORMANT Address: Mrs Shipley - Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James T. Marsh M.D.

EXAMINER'S NAME (Type) JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 9/25/56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 9-27-56

22c. NAME OF CEMETERY OR CREMATORY St Johns Cath.

22d. LOCATION (City, town, or county) (State) Westminster Md

23. FUNERAL DIRECTOR'S SIGNATURE Edw Stipton ADDRESS Hampstead Md

24a. REC'D BY REGISTRAR DATE Sept 30 56

24b. REGISTRAR'S SIGNATURE M D Lippy - Danner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09184

9195

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD

c. LENGTH OF STAY IN 1b: 32yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 101 N. MAIN St

d. STREET ADDRESS: 101 N. MAIN St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle MATRANGOLO Last Bellusci

4. DATE OF DEATH: Month Sept Day 9 Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 5. 1898

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Biaggio MATTRANGOLO

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Nick Bellusci — Address: HAMPSTEAD Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Suddenly
420.1
DUE TO
(b): Chronic Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) —

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State) —

21. I certify that I attended the deceased from March 2, 1946 to Sept 9, 1956 that I last saw the deceased alive on August 30, 1956, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E. Bush M.D. — ADDRESS (Street, city or town, state): Hampstead Md — DATE SIGNED: 9/8/56

PHYSICIAN'S NAME (Type): Joseph E. Bush MD — HAMPSTEAD MARYland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-12-56

22c. NAME OF CEMETERY OR CREMATORY: St Johns Catholic

22d. LOCATION (City, town, or county) (State): Westminster Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edes & Tipton — ADDRESS: Hampstead Md

24a. RECD BY REGISTRAR DATE: 9/10/56

24b. REGISTRAR'S SIGNATURE: Henry A. Culs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09185

9196

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

c. LENGTH OF STAY IN 1b 4 years 4 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.

d. STREET ADDRESS 417 E.Chase st.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Margaret Middle Frances Last Bond

4. DATE OF DEATH Month 9 Day 1 Year 1956

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 6-26-92

9. AGE (In years last birthday) 64 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Timothy Shanahan

14. MOTHER'S MAIDEN NAME Margaret Roche

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT Address Mrs George E,Bond (Husband) 417 E.Chase st.Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Stenosis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Rheumatic Heart Disease — DUE TO — years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia Bilateral, Pre-senile Psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-2, 1956, to 9-1-, 1956, that I last saw the deceased alive on 9-1-, 1956, and that death occurred at 5.30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Agustin del Campo M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9-2-56

PHYSICIAN'S NAME (Type) Agustin del Campo. Springfield State Hospital.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 9-5-56

22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer

22d. LOCATION (City, town, or county) (State) Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook Inc. 1212 Hanlon st.

24a. REC'D BY REGISTRAR DATE 9-2-56

24b. REGISTRAR'S SIGNATURE C. Harry Drew

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9190

CERTIFICATE OF DEATH

09186

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 61 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 224 E. Main Street

d. STREET ADDRESS: 224 E. Main Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Henry Last: Bowers

4. DATE OF DEATH: Month: September Day: 25 Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 15, 1872

9. AGE (In years last Birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ret Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Bldg. Con.

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Bowers

14. MOTHER'S MAIDEN NAME: Lucinda Frock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 226-03-6312

17. INFORMANT: Mrs. Wm. H. Bowers Address: Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Prostate & Liver — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypostasis (chr)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19[illegible], to Sept. 25, 1956, that I last saw the deceased alive on Sept 25, 19[illegible], and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Jennette M.D.
ADDRESS (Street, city or town, state): 103 E Main
DATE SIGNED:

PHYSICIAN'S NAME (Type): W. C. Jennette, M.D. 103 E. Main St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 28, 56
22c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley
22d. LOCATION (City, town, or county) (State): Pleasant Valley, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Byers ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 9-28-56
24b. REGISTRAR'S SIGNATURE: Hamet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09187

9197

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 15 yrs, 10 mos, 16 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Raspeburg
d. STREET ADDRESS: Chesaco Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Daniel; Middle; Last DAVIS
4. DATE OF DEATH: Month September; Day 27; Year 1956

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1885
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eleasar Davis
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
491x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Bilateral Chronic pyelonephritis — months
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Deficiency, Imbecility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 19 50 to September 27 1956, that I last saw the deceased alive on September 27, 19 56, and that death occurred at 10:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/28/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-1-56
22c. NAME OF CEMETERY OR CREMATORY: TRINITY CEMETERY
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: James J Bugzynski
ADDRESS: 1407 Eutaw
24a. REC'D BY REGISTRAR DATE: OCT 1 1956
24b. REGISTRAR'S SIGNATURE: C Harry Keen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09188

9198

Reg. Dist. No. 80

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CLARISSA Middle MAY Last DORSEY

4. DATE OF DEATH Month SEPT Day 2 Year 1956

5. SEX F

6. COLOR OR RACE COL

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH MAY 15 - 1956

9. AGE (In years last birthday) yrs. 3 IF UNDER 1 YEAR Months Days 18 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME NOT KNOWN

14. MOTHER'S MAIDEN NAME RUTHETTA DORSEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address RUTHETTA DORSEY NEW WINDSOR RURAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Infectious diarrhea — INTERVAL BETWEEN ONSET AND DEATH 24 hours

772.0

DUE TO (b) Malnutrition — 3 mo.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James T Marsh M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9-2-56

EXAMINER'S NAME (Type) JAMES T MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 9/3/56

22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY

22d. LOCATION (City, town, or county) LIBERTYTOWN (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE DD Hartzler & Sons ADDRESS New Windsor

24a. REC'D BY REGISTRAR DATE 9/3/56

24b. REGISTRAR'S SIGNATURE Emma L Rinehart

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

1000189XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9199

09189

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 2-24-55
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocky Ridge
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Grant; Middle: Ulysses S.; Last: DUBEL

4. DATE OF DEATH: Month: September; Day: 25; Year: 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1875

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Rocky Ridge, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Cornelius Dubel

14. MOTHER'S MAIDEN NAME: Caroline Damuth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital
Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Cerebrovascular accident — 4 weeks
DUE TO
(c): Arteriosclerosis — more than 1½ yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Hour o. m. p. m. ---; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1955, to Sept. 24, 1956, that I last saw the deceased alive on Sept. 24, 1956, and that death occurred at 8:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/25/56

PHYSICIAN'S NAME (Type): Martin Gross, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-28-1956
22c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Cem.
22d. LOCATION (City, town, or county) (State): Thurmont Fredk. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager
Raymond E. Creager
ADDRESS: Thurmontm, Md

24a. REC'D BY REGISTRAR DATE: OCT 1 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

92^0

CERTIFICATE OF DEATH

09190

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 60 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1034 Aisquith Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3V01-4

3. NAME OF DECEASED (Type or print): First: Dora; Middle:; Last: Ducson

4. DATE OF DEATH: Month: 9; Day: 29; Year: 1956

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: (Unknown)1891

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas or Tom Johnson

14. MOTHER'S MAIDEN NAME: Alice(Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Dora Melvin 1034 Aisquith St. Baltimore, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular insufficiency
0 1 2 3
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c): Tuberculosis of the left Carpal bones

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I ottended the deceosed from 7-30, 1956, to 9-29, 1956, that I last saw the deceased olive on 9-29, 1956, ond thot deoth occurred ot 8.30 P M, from the causes ond on the dote stoted above.

ACTUAL SIGNATURE: T.F. Vestal M.D. Henryton, Md.
ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): T.F. Vestal, M. D. Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Oct 3

22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary

22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: Adolphus Hobbs

ADDRESS: 918 Druid Ave

24a. REC'D BY REGISTRAR DATE: 10-1-56

24b. REGISTRAR'S SIGNATURE: Albert R. Swankhouse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9201

CERTIFICATE OF DEATH

09191

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1mo.;27days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 23 E. Patrick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

10-11-2

3. NAME OF DECEASED (Type or print): First: Katye; Middle: ; Last: DYER

4. DATE OF DEATH: Month: September; Day: 9; Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1871

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Ranneberger

14. MOTHER'S MAIDEN NAME: Martha - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT: Springfield Hospital records.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome; senility with psychosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 12, 19 56, to Sept. 9, 19 56, that I last saw the deceased alive on Sept. 9, 19 56, and that death occurred at 6:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/10/56

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-12-56
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet
22d. LOCATION (City, town, or county) (State): Frederick, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: M. R. Eichelberger Son. Frederick, Md
ADDRESS:
24a. REC'D BY REGISTRAR DATE: 9-10-56
24b. REGISTRAR'S SIGNATURE: C. Harry Ebert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9202

CERTIFICATE OF DEATH

10150 74

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 2/5/53
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ---
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 2234 N. Calvert St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Chester — Last: EBY

4. DATE OF DEATH: Month: September — Day: 4 — Year: 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 4, 1890

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months —, Days — — IF UNDER 24 HRS.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter - carpenter

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: James Eby

14. MOTHER'S MAIDEN NAME: Fannie -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Generalized arteriosclerosis with parkinsonism — more than 1 yr.

DUE TO

(c) ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral arteriosclerosis with psychotic reaction.) more than 3 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 —

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from June 22, 1953, to Sept. 4, 1956, that I last saw the deceased alive on Sept. 4, 1956, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. — ADDRESS (Street, city or town, state): Sykesville, Maryland — DATE SIGNED: 9/5/56

PHYSICIAN'S NAME (Type): Martin Gross, M. D. — c/o Springfield State Hospital

22a. BURIAL, CREMATION, REMOVAL (Specify): Embalmed

22b. DATE THEREOF: 9/12/56

22c. NAME OF CEMETERY OR CREMATORY: U. of Md.-Med.-Sched.

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Newell & Sons — ADDRESS: Pikesville

24a. REC'D BY REGISTRAR DATE: SEP 15 1956

24b. REGISTRAR'S SIGNATURE: C. Gary Hupp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

09192

9203

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 3 y. 8 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9708 Lawndale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-56-2

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Ferguson

4. DATE OF DEATH: Month: Sept. — Day: 18 — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-23-1889

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Henry King

14. MOTHER'S MAIDEN NAME: Mary Ella Gaywood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary artery embolism. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

416 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chronic rheumatic heart disease. — Years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic depressive reaction, manic type

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-26, 19 52, to 9-18, 19 56, that I last saw the deceased alive on 9-18, 19 56, and that death occurred at 9:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerhard Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/18/1956

PHYSICIAN'S NAME (Type): Gerhard Sonnenfeldt M.D. Springfield State Hospital Sykesville Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9/21/56

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey, — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 9-25-56

24b. REGISTRAR'S SIGNATURE: C. Henry Tuer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09193

9204

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 13yrs.;10mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1316 Poplar Grove St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herman; Middle; Last Fisher

4. DATE OF DEATH: Month September; Day 18; Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 12/15/94

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Hair Cutting

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: John Fisher

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Springfield Hospital records.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myodardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Days

420.0

DUE TO
(b): Coronary occlusion — Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerotic heart disease — Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis with chronic alcoholism; Korsakow's Syndrome.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to Sept. 18, 1956, that I last saw the deceased alive on Sept. 18, 1956, and that death occurred at 2:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/19/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-21-56
22c. NAME OF CEMETERY OR CREMATORY: Springfield
22d. LOCATION (City, town, or county) (State): Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Haught
ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: 9-21-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9205

09194

CERTIFICATE OF DEATH

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 years 6½ m.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 3300 Glenmore Ave

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DRUSILLA Middle DIEHL Last GILPIN

4. DATE OF DEATH: Month Septem. Day 10 Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8.30.1877

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACOB DIEHL

14. MOTHER'S MAIDEN NAME: Addie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: GEORGE GILPIN
Address: 544 Strathmore Ave Balto
~~3300 Glenmore Ave~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute heart failure
450.0
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 15 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 8, 1956, to Sept. 10, 1956, that I last saw the deceased alive on Sept. 8, 1956, and that death occurred at 2:45 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Valdis Aizkraukl M.D.
ADDRESS (Street, city or town, state): Springfield State Hospit
DATE SIGNED: 9-10-56

PHYSICIAN'S NAME (Type): VALDIS AIZKRAUKLIS MD Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9-13-1956

22c. NAME OF CEMETERY OR CREMATORY: Memorial Morehead Cem

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Glenn F Seitz
ADDRESS: 5209 York Rd

24a. REC'D BY REGISTRAR DATE: SEP 13 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Heeza

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9206 **CERTIFICATE OF DEATH** 09195

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 38yrs. 8mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 Y01-4
d. STREET ADDRESS: Chapel Street (?)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: -- — Last: Goodwin

4. DATE OF DEATH: Month: 9 — Day: 28 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-1-1891

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Goodwin

14. MOTHER'S MAIDEN NAME: Mamie Fersch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT — Address: Hospital records - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of uterus with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 3yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Diabetes — 6yrs.
DUE TO
(c):

174X 260

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-11- 1942, to 9-27- 1956, that I last saw the deceased alive on 9-27- 1956, and that death occurred at 12:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Morrell N. Mastin M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville, Maryland
DATE SIGNED: 9-28-56

PHYSICIAN'S NAME (Type): Morrell N. Mastin, M.D. — Springfield State Hospital, Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-1-56
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Haight — ADDRESS: Sykesville Md.

24a. REC'D BY REGISTRAR — DATE: 10-1-56
24b. REGISTRAR'S SIGNATURE: C. Henry Beer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09196

9207

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 yr, 16 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaither
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: Robert — Last: HARDING

4. DATE OF DEATH: Month: September — Day: 26 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 1/8/81

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert A. Harding

14. MOTHER'S MAIDEN NAME: Luella Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT — Address: Springfield State Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

420.0

DUE TO
(b): Arteriosclerotic Heart Disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 10 19 55 to September 26 19 56, that I last saw the deceased alive on September 26, 19 56, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/27/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-29-56
22c. NAME OF CEMETERY OR CREMATORY: Springfield
22d. LOCATION (City, town, or county) (State): Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR — DATE: 9-28-56
24b. REGISTRAR'S SIGNATURE: C. Harry Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG206 11-9-56 et

09197

9208

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, 18
d. STREET ADDRESS: 4104 The Alameda
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anne; Middle: Cecilia; Last: HOPKINS

4. DATE OF DEATH: Month: September; Day: 14; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 4, 1877

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): File Clerk

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Samuel~~ Hopkins

14. MOTHER'S MAIDEN NAME: Charles M. Hopkins Catherine Hammer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Springfield State Hospital records.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — Years:
(c): Fracture of neck of right femur, reduced. — 14 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with generalized arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Unknown

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year: 8/31/1956

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Balto. City Md.

21. I certify that I attended the deceased from 9/11/1956, to 9/14/1956, that I last saw the deceased alive on September 14, 1956, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/14/56

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 17,1956
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemt.
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Moran
ADDRESS: 3000 E. Baltimore St.

24a. REC'D BY REGISTRAR DATE: SEP 17 1956

24b. REGISTRAR'S SIGNATURE: C. Barry Keirs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09198

9209

CERTIFICATE OF DEATH

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Mont.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland — c. LENGTH OF STAY IN 1b: 2yrs. 10 mos	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 7504 Holly Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Alice	Middle: Grace	Last: ISRAEL	4. DATE OF DEATH	Month: 9	Day: 6 — Year: 1956
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 8-;3-90	9. AGE (In years last birthday): 66 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Charles S. Linthicum		14. MOTHER'S MAIDEN NAME: Alice Purdum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Unk — (If yes, give war or dates of service): ------	16. SOCIAL SECURITY NO.: Unk	17. INFORMANT: ISRAEL Charles I. — Address: 7504 Holly St. Takoma Park	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	3 days.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Chronic brain syndrome, associated with	
DUE TO (c)	Circulatory disturbance with psychotic reaction.	7 Years

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from 12-5-53, 19 53 to 9-6-, 19 56 that I last saw the deceased alive on 9-6-56, 19 , and that death occurred at 10-40 M, from the causes and on the date stated above.

9-6-56 DATE SIGNED

ACTUAL SIGNATURE: Dr Ilse Kamm M.D.

ADDRESS (Street, city or town, state): 4 Grandview, Sykesville, Md.

PHYSICIAN'S NAME (Type): Dr Ilse Kamm

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 9-8-56	22c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery	22d. LOCATION (City, town, or county): Beallsville	(State): Md.	
23. FUNERAL DIRECTOR'S SIGNATURE: Ob Farmer	ADDRESS: Buckeystown Md	24a. REC'D BY REGISTRAR DATE: 9-10-56	24b. REGISTRAR'S SIGNATURE: C. Harry Eller		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9210

09199

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodstock
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Henry — Last: Jenkins

4. DATE OF DEATH: Month: September — Day: 16 — Year: 1956

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 5-15-88 — 9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Work
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hurley Jenkins
14. MOTHER'S MAIDEN NAME: Judy Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Records of Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Intestinal hemorrhage	1 day
DUE TO	intestinal gangrene due to Tuberculous peritonitis	years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)		years
(c)	Tuberculous empyema	years

0030

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 14, 1954, to Sept. 16, 1956, that I last saw the deceased alive on Sept. 15, 1956, and that death occurred at 3:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. — ADDRESS (Street, city or town, state): Sykesville, Md. — DATE SIGNED: Sept. 16, 1956

PHYSICIAN'S NAME (Type): Martin Gross, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-19-56
22c. NAME OF CEMETERY OR CREMATORY: Mt View
22d. LOCATION (City, town, or county) (State): Howard Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur A. Haight — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: 9-17-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09200

: 9211

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 38yrs.4mos.9days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 3004 Dillon Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude; Middle: ; Last: JONDO

4. DATE OF DEATH: Month: September; Day: 21; Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 65 ? yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital records.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
443X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus. Dementia Praecox, catatonic type.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to September 21 1956, that I last saw the deceased alive on September 20, 1956, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/21/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 25-56
22c. NAME OF CEMETERY OR CREMATORY: Belair Mem. Gardens
22d. LOCATION (City, town, or county) (State): Belair Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Connelly
ADDRESS: 3500 Bank St.
24a. REC'D BY REGISTRAR DATE: SEP 25 1956
24b. REGISTRAR'S SIGNATURE: Catharine Keers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9212 — 09201 — Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Burial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Bridge
d. STREET ADDRESS: Farquhar St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle LEE — Last KEFAUVER

4. DATE OF DEATH: Month SEPT — Day 8 — Year 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/23/1940

9. AGE (If years, last birthday): 15 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Calvin Richard Kefauver

14. MOTHER'S MAIDEN NAME: Mary Catherine Fogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-38-1496

17. INFORMANT: Address: Mary C. Kefauver, Union Bridge Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): FRACTURE SKULL — INTERVAL BETWEEN ONSET AND DEATH:

825x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Automobile Accident

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile accident

20c. TIME OF INJURY: Hour 12:15 a. m. p. m. — Month, Day, Year: 9-8 1956

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Uniontown Rd

20f. (City or town) (County) (State): Westminster Carroll Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/8/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/10/56 — 22c. NAME OF CEMETERY OR CREMATORY: Winters Cem. — 22d. LOCATION (City, town, or county) (State): Carroll County Md

23. FUNERAL DIRECTOR'S SIGNATURE: W. D. Fritchey Sons — ADDRESS: Union Bridge Md

24a. REC'D BY REGISTRAR — DATE: 9-11-56 — 24b. REGISTRAR'S SIGNATURE: Hamet Hinkle

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9213 **CERTIFICATE OF DEATH** 09202

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 1 yr. & 3mos.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City (12) 3 Y 01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 1340 Crofton Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUISA Middle ELIZABETH Last KENNEY

4. DATE OF DEATH: Month September Day 15, Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1873

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Holtzner

14. MOTHER'S MAIDEN NAME: Mary Batchler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT (Daughter) Address: Mrs. Ida Kenney Council-1240 Crofton Rd., Balto. 12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: One (1) month
443X
DUE TO: Chronic Hypertensive Cardio-vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 17.11 CBS Assoc. with metabolis disturbance, with senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 4, 1955, to September 15 1956, that I last saw the deceased alive on Sept. 15, 1956, and that death occurred at 2:20P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Valdis Aizkrauklis M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/15/56

PHYSICIAN'S NAME (Type): Valdis Aizkrauklis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/18/1956

22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Buck — ADDRESS: 5305 Harford Rd.

24a. REC'D BY REGISTRAR DATE: 9-15-56

24b. REGISTRAR'S SIGNATURE: C. Harry Weed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9214

CERTIFICATE OF DEATH

Reg. Dist. No. 0920 3

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 27y,11mos.23da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George; Middle; Last KOPOLSKI

4. DATE OF DEATH: Month September; Day 5; Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1870 ?
9. AGE (In years last birthday): ? 86 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mary -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) General Arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Epilepsy with mental deficiency. Bronchopneumonia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to September 5, 1956, that I last saw the deceased alive on September 5, 1956, and that death occurred at 10:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/5/56
PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/8/56
22c. NAME OF CEMETERY OR CREMATORY: Cathedral
22d. LOCATION (City, town, or county) (State): Ft. Tedrick Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. L. Foley & Sons
ADDRESS:
24a. REC'D BY REGISTRAR DATE: SEP 7 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Stay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09204

9215 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1124 S.Robinson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Naomi; Middle: Grace; Last: KUNSKY

4. DATE OF DEATH: Month: September; Day: 15; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 20, 1918

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Redmann

14. MOTHER'S MAIDEN NAME: Margaret Lawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-01-3948

17. INFORMANT: Springfield State Hospital records.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
322.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute suppurative pancreatitis — Days
DUE TO
(c) Acute alcoholism — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute brain syndrome due to alcoholism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T Marsh M.D.
EXAMINER'S NAME (Type): James T. Marsh, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/16/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/20/56
22c. NAME OF CEMETERY OR CREMATORY: Moreland Mem.Park.
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.F. Hoffmann
ADDRESS: 3218 Hudson St (24)

24a. RECD BY REGISTRAR — DATE: SEP 19 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Key

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9216

CERTIFICATE OF DEATH

09205 Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 2 mos., 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5700 Bradley Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NICKOLAS; Middle GEORGE; Last LAIOS

4. DATE OF DEATH: Month 9; Day 5; Year 19 56

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1864
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): hat-cleaning
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Laios
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Record, Springfield State Hospital, Sykesville — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with senile brain disease with psychosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/3, 19 56, to 9/5, 19 56, that I last saw the deceased alive on 9/5, 19 56, and that death occurred at 9:35A M. DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: Julian Radzykewycz M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/5/56

PHYSICIAN'S NAME (Type): Julian Radzykewycz, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/8/56
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Bladensburg md

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
24a. REC'D BY REGISTRAR DATE: SEP 10 1956
24b. REGISTRAR'S SIGNATURE: C. Larry Veerp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9217 — 09206 — Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3yrs;11mos;14da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2435 Lakeview Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frank; Middle; Last LEVINSON

4. DATE OF DEATH: Month September; Day 20; Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1886

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser

10b. KIND OF BUSINESS OR INDUSTRY: York

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? Russia

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: York

17. INFORMANT: Springfield Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
526X
DUE TO
(b): Chronic bronchiectasis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 6, 1952, to September 20 1956, that I last saw the deceased alive on September 20, 1956, and that death occurred at 8:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/21/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-23-56
22c. NAME OF CEMETERY OR CREMATORY: Herring Run
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Jack Lewis Inc — ADDRESS: 2100 Eutaw Place

24a. REC'D BY REGISTRAR DATE: 9-24-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG204 9-19-56 et

9218

09207

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 10mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Montgomery~~ Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Gaithersburg~~ Baltimore 7
d. STREET ADDRESS: c/o Miss Florence Neal, Wetheredsville ~~Asbury Methodist Home~~ Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Emma — Last: Lilley

4. DATE OF DEATH: Month: 9 — Day: 10 — Year: 1956

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-21-1871

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S. A.

13. FATHER'S NAME: Emanual E. Pierce

14. MOTHER'S MAIDEN NAME: Alice V. Triplett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: ----

17. INFORMANT (Name): 2709 E. Federal St.
Mrs. John E. Johnson Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebreal hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
331x
DUE TO
Conditions, if any, which gove rise to immediate couse (a), stating the underlying cause last.
(b) Genl. Arterio Sclersis — 15 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-9- , 1956, to 10-10 , 1956, that I last saw the deceased alive on 10-10 , 1956, and that death occurred at 11:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED: Sept 11-56

PHYSICIAN'S NAME (Type): Dr. M. N. Mastin — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/14/56
22c. NAME OF CEMETERY OR CREMATORY: Ward's Chapel Cem.
22d. LOCATION (City, town, or county) (State): Balto. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tichner & Sons - Balto 17 — ADDRESS

24a. REC'D BY REGISTRAR DATE: SEP 13 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Kerr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9219

CERTIFICATE OF DEATH

09208 Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER

c. LENGTH OF STAY IN 1b ALL HIS LIFE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTMINSTER RD#4

d. STREET ADDRESS OLD BALTIMORE BLVD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last LOCKARD

4. DATE OF DEATH Month SEPT. Day 3 Year 1956

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH SEPT 18, 1866

9. AGE (In years last birthday) 89 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER

10b. KIND OF BUSINESS OR INDUSTRY FARM & INDUSTRY

11. BIRTHPLACE (State or foreign country) CARROLL CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JESSE LOCKARD

14. MOTHER'S MAIDEN NAME MARGARET TURFLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Address LIONEL LOCKARD, WESTMINSTER RT RD #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4 yrs
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 56 to Sept 3 19 56 that I last saw the deceased alive on Sept 3, 19 56 and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. Eugene Wilkens

ADDRESS (Street, city or town, state) 15 Penn Ave Westminster Md

DATE SIGNED 9/4/56

PHYSICIAN'S NAME (Type) EUGENE WILKENS

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF Sept. 6, 56

22c. NAME OF CEMETERY OR CREMATORY CARROLLTON CHURCH

22d. LOCATION (City, town, or county) (State) CARROLLTON CARROLL CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr.

ADDRESS Westminster Md

24a. REC'D BY REGISTRAR DATE 9-5-56

24b. REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9191 **CERTIFICATE OF DEATH**

09209 Reg. Dist. No. 6

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 174 Penna. Ave.
d. STREET ADDRESS: 174 Penna Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret Middle Ann Last Massicot

4. DATE OF DEATH: Month Sept. Day 7 Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 24, 1870
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Westminster, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George A. Chrest
14. MOTHER'S MAIDEN NAME: Jane Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: - - - - - -
17. INFORMANT: Mrs. Mary Eckard Address: Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Cardio Renal Vascular — 5 yrs

DUE TO (c):

4427

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 21 1956 to Sept 7 1956, that I last saw the deceased alive on Sept 7 1956, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas R. Foutz M.D. ADDRESS (Street, City or Town, State): Westminster Md DATE SIGNED

PHYSICIAN'S NAME (Type): Charles R. Foutz, Md. 148 W. Main St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-10-56
22c. NAME OF CEMETERY OR CREMATORY: St. John's Catholic
22d. LOCATION (City, town, or county) (State): Westminster, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John R. Byers Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 9-12-56
24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9220 09210

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 38y;8mos;15days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anton; Middle; Last MIKUS

4. DATE OF DEATH: Month September, Day 7, Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 61 ? yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unk

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY? Lithuania

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 159 ×
(b): Gastro-intestinal neoplasm — Months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, catatonia type; Bronchopneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955 to September 7 1956, that I last saw the deceased alive on September 6, 1956, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo. M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/7/56

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-10-56
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: 9-10-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9221

CERTIFICATE OF DEATH

09211

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY: Carroll County — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 3 Yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 7 Westminster

d. STREET ADDRESS: 7 Westminster St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles Middle: E. Last: Monath

4. DATE OF DEATH: Month: September Day: 2 Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 4, 1875

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: 5 Days: 29 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cranberry, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Christian Monath

14. MOTHER'S MAIDEN NAME: Krenzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-22-9639

17. INFORMANT (Address): 7 Westminster St
Mrs. Marian Monath, Manchester, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week
331X
DUE TO
(b): Hypertension + arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1st cerebral hemorrhage Jan. 1956

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1-50, 19__ to 9-2-, 19 56, that I last saw the deceased alive on 9-1-, 19 56, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James G Saffell M.D.
ADDRESS (Street, City or town, State): Reisterstown Md
DATE SIGNED: 9-3-56

PHYSICIAN'S NAME (Type): JAMES G. SAFFELL Reisterstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-5-56
22c. NAME OF CEMETERY OR CREMATORY: St. Davids Cemetery
22d. LOCATION (City, town, or county) (State): York County, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: David R. Martin
ADDRESS: David R. Martin, Manchester, Md

24a. REC'D BY REGISTRAR DATE: SEP 6 1956
24b. REGISTRAR'S SIGNATURE: Mrs. H. B. J. Dennis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09212

9222 # CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH

COUNTY CARROLL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR

LENGTH OF STAY (in this place) YEARS

HOSPITAL OR INSTITUTION OR STREET ADDRESS MAIN STREET

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY CARROLL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR

STREET ADDRESS (If rural give location) MAIN STREET

3. NAME OF DECEASED (Type or Print) (First) ALICE (Middle) MARIE (Last) PATTERSON

4. DATE OF DEATH (Month) SEPT (Day) 1 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	COL	M	2/11/1894	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	DOMESTIC	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ROBERT JONES	CORA DORSEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	212-16-4940	ARTHUR PATTERSON New Windsor Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

201X IMMEDIATE CAUSE (A) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH 10 years.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, to Sept 1, 1956, that I last saw the deceased alive on Aug 31, 1956, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

SIGNATURE	M.D.	ADDRESS (Street, city, town, state)	DATE SIGNED
James J. Marsh		Westminster Md	9/1/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	9/4/56	MT OLIVE	FREDERICK Co. MD.

24. REC'D BY REGISTRAR DATE 8/~~31~~/56 9/3/56	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
	Evan D Bowers	D D Hartzler & Sons	New Windsor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7,10,11,13,14, 15 FilmG20h 9-25-56 et

09213

Reg. Dist. No. 74

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Val-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital	d. STREET ADDRESS: 223 S. Durham Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John		Petrakov	9	1	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White			51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Russia	✓

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Petrakov	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging — INTERVAL BETWEEN ONSET AND DEATH

E974X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	Hanged self from tree.

20c. TIME OF INJURY Hour o. m. p. m. / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Unknown 19		Field	Carroll Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Paul F. Guerin M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☒ — DEPUTY MEDICAL EXAMINER ☐ — DATE SIGNED 9/14/56

EXAMINER'S NAME (Type) Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	9-18-56	ST. ANDREW'S CEM	GERMAN HILL RD., MD

23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Charles L. Zeller 9015 CONKLING ST. BALTO. 24, MD	SEP 20 1956	C. Harry Klein

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09214

9224

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 1 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First FRANCIS — Middle A — Last POUDER

4. DATE OF DEATH: Month Sept Day 21 Year 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: April 30 - 1880

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: B & O Ry Employe

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm H. Pouder

14. MOTHER'S MAIDEN NAME: Martha A Wampler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Address: Francis L Pouder - Romney W. Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pulmonary Tuberculosis — 6 yrs
DUE TO
(c):

525 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1 19 49 to Sept 21 19 56, that I last saw the deceased alive on Sept 20 19 56, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W H Foard M.D.
ADDRESS (Street, city or town, state): Manchester Md
DATE SIGNED: 9/21/56

PHYSICIAN'S NAME (Type): W. H. Foard M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 24/56
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge
22d. LOCATION (City, town, or county) (State): Balto Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw L Tipton
ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: Sept 21-56
24b. REGISTRAR'S SIGNATURE: Mrs. W.R. Downer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09215

9225

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 yr, 17 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll 085
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodsboro
d. STREET ADDRESS: Oak Hill, Woodsboro
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Horace — Middle Daniel — Last Radcliff

4. DATE OF DEATH: Month 9 — Day 30 — Year 1956

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: ~~unknown~~ 12/6/83

9. AGE (In years last birthday): 72 71? yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store keeper

10b. KIND OF BUSINESS OR INDUSTRY: Confectionary ~~own Business~~

11. BIRTHPLACE (Stote or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel S. Radcliff

14. MOTHER'S MAIDEN NAME: Margaret Garver

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Generalized arteriosclerosis — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbances with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that I attended the deceased from 9-13- 1955 to 9-30- 1956, that I last saw the deceased alive on 9-30-56 1956, and that death occurred at 8.45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, stote): Springfield State Hospital.
DATE SIGNED: 9-30-56

PHYSICIAN'S NAME (Type): Agustin del Campo. M.D.
Sprinfield State Hosputal, Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 2, 1956
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Rocky Hill
22d. LOCATION (City, town, or county) (Stote): W. Woodsboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. C. Barton, Walkersville, Md.

24a. REC'D BY REGISTRAR DATE: 30 Oct. 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Horn

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9226

CERTIFICATE OF DEATH

09216

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 32 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gamber

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
d. STREET ADDRESS: Gamber
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle William — Last Reese

4. DATE OF DEATH: Month Sept. — Day 8 — Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 15, 1876

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis W. Reese

14. MOTHER'S MAIDEN NAME: Jane Coppersmith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 216-10-4865

17. INFORMANT: Mrs. John W. Reese — Address: Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 9-1-56
DUE TO
(b): arteriosclerosis — 4 years
DUE TO
(c): Hypertension — 2 yrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1-56, to 9-8-56, that I last saw the deceased alive on 9-8-56, and that death occurred at 6 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James G Saffell M.D.
ADDRESS (Street, city or town, state): Reisterstown Md
DATE SIGNED: 9-10-56

PHYSICIAN'S NAME (Type): James G. Saffell
Reisterstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 11, 56
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant
22d. LOCATION (City, town, or county) (State): Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J.E.Myers Jr.
ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 9-11-56
24b. REGISTRAR'S SIGNATURE: Hamit Mull

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09217

CERTIFICATE OF DEATH

9227

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 1 yr. 2 mos.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1054 Lerew Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna — Middle Mary — Last Reuttinger

4. DATE OF DEATH: Month Sept. — Day 6 — Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1-22-90

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Lubbehusen

14. MOTHER'S MAIDEN NAME: Susana Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: one-half hour

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic hypertension — Several years

DUE TO (c): Diabetes mellitus — Several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Involutional Psychotic Reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-13, 1955, to 9-6, 1956, that I last saw the deceased alive on 9-6, 1956, and that death occurred at 9:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Valdis Aizkrauklis, M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/6/56

PHYSICIAN'S NAME (Type): Valdis Aizkrauklis
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-10-56
22c. NAME OF CEMETERY OR CREMATORY: St Peters
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. Cook, Inc.
ADDRESS: 1217 E Pratt St.

24a. REC'D BY REGISTRAR DATE: 5-6-56
24b. REGISTRAR'S SIGNATURE: C. Hargrave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9228

CERTIFICATE OF DEATH

09219

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carrol — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 27½ months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Md
d. STREET ADDRESS: 3736 Gough St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth — Middle ——— — Last Schultz

4. DATE OF DEATH: Month September — Day 14 — Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-11-1878

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland, USA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Groskote

14. MOTHER'S MAIDEN NAME: Maggie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Benjamin Schultz, 3504 Fleet St, Balto 24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 17 hrs

450.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerosis — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS ass with Disturb. of Metabolism, Growth or Nutr. with Senile Brain Disease with Psychotic Reaction.

19. WAS AUTOPSY PERFORMED? ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW ACCIDENT occurred. (Describe fully nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 1954, to Sep 13, 1956, that I last saw the deceased alive on Sep 13, 1956, and that death occurred at 2:40 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Irene L. Hitchman, M.D. ADDRESS (Street, city or town, state): Sykesville, Md. DATE SIGNED: 9-14-56

PHYSICIAN'S NAME (Type): Irene L. Hitchman, MD — Sykesville, Md — 9.14.56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 17-56

22c. NAME OF CEMETERY OR CREMATORY: Moreland Memorial

22d. LOCATION (City, town, or county) (State): Taylor Ave. Balto Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Connelly — ADDRESS: 418 Eastern Blvd

24a. RECEIVED BY REGISTRAR DATE: SEP 17 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Warp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09220

9229

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8½ yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: ——
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3Y01-4
d. STREET ADDRESS: 2723 Oakley Ave. City Hospital Infirmary
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence — Middle: Edward — Last: Scott

4. DATE OF DEATH: Month: Spt. — Day: 3 — Year: 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1892 June 4

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months: —— Days: ——
IF UNDER 24 HRS.: Hours: —— Min.: ——

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Richmond, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roger Scott

14. MOTHER'S MAIDEN NAME: Rosa Candle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT — Address: Records of Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	seconds
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Generalized arteriosclerosis	over 10 yrs
(c)		

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ——

20c. TIME OF INJURY: Hour a. m. p. m. —— Month, Day, Year 19 ——

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ——

20f. (City or town) (County) (State): ——

21. I certify that I attended the deceased from Aug. 12, 1948, to Spt. 3, 1956, that I last saw the deceased alive on Spt. 2, 1956, and that death occurred at 2:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. ADDRESS (Street, city or town, state): Springfield State Hosp. DATE SIGNED: 9-3-56

PHYSICIAN'S NAME (Type): Martin Gross, M.D. Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/5/56
22c. NAME OF CEMETERY OR CREMATORY: Maury Cemetery
22d. LOCATION (City, town, or county) (State): Richmond, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John O. Mitchell & Sons 1900 Eutaw Place

24a. REC'D BY REGISTRAR DATE: 9-3-56

24b. REGISTRAR'S SIGNATURE: C. Henry Uhler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9230

CERTIFICATE OF DEATH

09221

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Zone 21
d. STREET ADDRESS: 536 Back River Neck Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03-54-2

3. NAME OF DECEASED (Type or print): First: Grace Virginia Edwards — Middle — Last: SEVIER

4. DATE OF DEATH: Month: September — Day: 20 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 6, 1902
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Edwards
14. MOTHER'S MAIDEN NAME: Anna DeBruler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Springfield State Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: Hours

605X

DUE TO (b): Ruptured urinary bladder — Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Cystitis — 4 wks. plus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congenital atrial septal defect. Schizophrenic reaction, catatonic type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 22, 1956, to September 20 1956, that I last saw the deceased alive on September 20, 1956, and that death occurred at 2:05 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/21/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 24-56
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
22d. LOCATION (City, town, or county) (State): Chase Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Thos. S. Connolly Essex Md.
24a. REC'D BY REGISTRAR DATE: SEP 25 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Keers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09222

9231

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 10-5-53
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ---
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 832 S. Bond Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Chauncey — Middle: Maurice — Last: SMITH

4. DATE OF DEATH: Month: September — Day: 27 — Year: 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 3, 1903

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet metal worker

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Levin J. Smith

14. MOTHER'S MAIDEN NAME: Margaret Carew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital
Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): Central nervous system syphilis — more than 3 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis with syphilitic meningo-encephalitis - years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from Feb. 26, 1954, to Sept. 27, 1956, that I last saw the deceased alive on Sept. 27, 1956, and that death occurred at 8:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/28/56

PHYSICIAN'S NAME (Type): Martin Gross, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/1/56
22c. NAME OF CEMETERY OR CREMATORY: Trinity Cem
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: Philip Herwig Sons
ADDRESS: 2024 Orleans

24a. REC'D BY REGISTRAR DATE: OCT 1 1956
24b. REGISTRAR'S SIGNATURE: C Harry Kerr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9232

CERTIFICATE OF DEATH

09223

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 48yrs;7mos;3days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1100 S. Paca St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: E. — Last: SMITH

4. DATE OF DEATH: Month: September — Day: 23 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1879

9. AGE (In years last birthday): 77 ? yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woodworker

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Unknown~~ John Smith

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Louise Deitchman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: none -

17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic heart disease. — Months

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, hebephrenic type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to September 23 1956, that I last saw the deceased alive on September 23, 1956, and that death occurred at 11:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/24/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/27/56
22c. NAME OF CEMETERY OR CREMATORY: Western Cem.
22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WM. J. TICKNER & SONS - Balto. 17, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 28 1956

24b. REGISTRAR'S SIGNATURE: C. Barry Keeney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09224

9233 # CERTIFICATE OF DEATH

Reg. Dist. No. 7-4

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

LENGTH OF STAY (In this place): 6 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Grand View Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Baltimore

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glyndon, Md.

STREET ADDRESS (If rural give location): Glyndon Ave.

3. NAME OF DECEASED (Type or Print): (First) Rosamond (Middle) E. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Single	Aug. 18, 1885	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Art Teacher		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Walsh Smith	Mary Elizabeth Leas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		Mrs. Ira Wales, Glyndon, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

202.1 IMMEDIATE CAUSE (A) Lymphoblastoma — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs. 7 mos.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive C-V Disease — 17 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-13-56	Giant Follicular Lymphoblastoma	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	none	none

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
none	none	none

22. I hereby certify that I attended the deceased from 10-25, 1936, to 9-16, 1956, that I last saw the deceased alive on 9-12, 1956, and that death occurred at 8 A M, from the causes and on the date stated above.

SIGNATURE: D. L. Caples, M.D. — ADDRESS (Street, city, town, state): 6 Hanover Rd., Reisterstown, Md. — DATE SIGNED: 9-17-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 18/56	Druid Ridge	Pikesville, Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE 9-17-56	C. Harry Shue	J.F. Eline & Sons, Reisterstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09225

9192 **CERTIFICATE OF DEATH**

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b 40 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 67 RALPH ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 67 RALPH ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EMMA Middle MAY Last SPENCER
4. DATE OF DEATH Month SEPT. Day 21 Year 1956
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MARCH 31-1872
9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS SPENCER
14. MOTHER'S MAIDEN NAME REBECCA FLATER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address MRS HARVEY RITTER 67 RALPH ST. WESTMINSTER MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardio Vascular Renal Disease	4 yrs
DUE TO (b)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerosis & Hypertension	5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		

4424

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 53, to Sept 21, 1956, that I last saw the deceased alive on Sept 19, 1956, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN'S NAME (Type) Wm. Speicher M.D. ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 9/23/56

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 9-23-56
22c. NAME OF CEMETERY OR CREMATORY SANDYMOUNT C.E.M.
22d. LOCATION (City, town, or county) (State) CARROLL Co. MD.
23. FUNERAL DIRECTOR'S SIGNATURE H. Bankard & Son ADDRESS Westminster Md
24a. REC'D BY REGISTRAR DATE 9-24-56
24b. REGISTRAR'S SIGNATURE Vannet Rubin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09226

9234

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linwood Rural
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Linwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mary; Middle: C.; Last: Spielman

4. DATE OF DEATH: Month: September; Day: 7; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: January 27, 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Baker

14. MOTHER'S MAIDEN NAME: Mary Alice Nusbaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles J. Spielman, Jr., Linwood, Maryland
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1956 to Sept 7 1956 that I last saw the deceased alive on Sept 7 1956 and that death occurred at 2 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Reese Wilkens M.D.
ADDRESS (Street, city or town, state): 15 Kenilworth Ave Hagerstown
DATE SIGNED: 9/9/56

PHYSICIAN'S NAME (Type): E. Reese Wilkens

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 10, 1956

22c. NAME OF CEMETERY OR CREMATORY: Winter's Cemetery

22d. LOCATION (City, town, or county) (State): Linwood, Carroll, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Emerson C. Fuss
ADDRESS: Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: 9/9/56

24b. REGISTRAR'S SIGNATURE: Margaret R. Engle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09227

9235

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westminster

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westminster, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster, Md. R.D.1 (Silver Run)

d. STREET ADDRESS: Westminster, Md. R.D.1 (Silver Run)

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma Middle Catherine Last Stair

4. DATE OF DEATH: Month 9/22/56 Day Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/18/1902

9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife, Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Theodore Zepp

14. MOTHER'S MAIDEN NAME: Mary Catherine Wantz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-14-2135

17. INFORMANT: Newton O. Stair Address: Newton O. Stair, R.D.1, Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

443X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 1956, to Sept 22, 1956, that I last saw the deceased alive on Sept. 18, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leah Abel Maitland M.D. ADDRESS (Street, city or town, state): 50 Maple Avenue DATE SIGNED: 9/22/56

PHYSICIAN'S NAME (Type): LEAH ABEL MAITLAND Littlestown Pa

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/24/56

22c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley Cemetery

22d. LOCATION (City, town, or county) (State): Pleasant Valley, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little ADDRESS: Littlestown, Pa.

24a. REC'D BY REGISTRAR DATE: 9-24-56

24b. REGISTRAR'S SIGNATURE: Harriet Mullen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09228

9236 # MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester Rural
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Adams — Last: Staub

4. DATE OF DEATH: Month: September — Day: 24 — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 13, 1880

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Adams Co, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Staub

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mervin — Address: Mr Marvin Staub Manchester, Md. R.D.#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W H Foard M.D.
EXAMINER'S NAME (Type): W.H. Foard M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/24/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/28/56
22c. NAME OF CEMETERY OR CREMATORY: Mummerts
22d. LOCATION (City, town, or county) (State): East Berlin Pa Adams Co

23. FUNERAL DIRECTOR'S SIGNATURE: Frederick Buckis Hanover Pa
ADDRESS:

24a. REC'D BY REGISTRAR: DATE Sept 24-56
24b. REGISTRAR'S SIGNATURE: Mrs. Wpl. Demmer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9237 **CERTIFICATE OF DEATH** Reg. Dist. No. 092294

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 104 N. Green, St., 2nd fl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last SUCK

4. DATE OF DEATH: Month September — Day 26 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/21/97

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Suck

14. MOTHER'S MAIDEN NAME: Altie West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic Heart Disease — unknown

DUE TO

(c) General Arteriosclerosis — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) phrase: Chronic brain syndrome associated with alcoholism without qualifying

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 6, 1956, to September 26 1956, that I last saw the deceased alive on September 25, 1956, and that death occurred at 2:07 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/26/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Oct 1 1956

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WM. COOK Inc. 1215 St. Paul Street Balto 2 Md.

24a. REC'D BY REGISTRAR DATE: OCT 1 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Keen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09230

9238

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER
c. LENGTH OF STAY IN 1b 40 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN CHAPEL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER, Md.
d. ~~STREET~~ ADDRESS NEW WINDSOR #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First STERLING Middle FRANKLIN Last THOMAS

4. DATE OF DEATH Month SEPT. Day 18 Year 1956

5. SEX MALE

6. COLOR OR RACE COLORED

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH JAN. 11, 1906

9. AGE (In years last birthday) 50 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER

10b. KIND OF BUSINESS OR INDUSTRY DAIRY FARM

11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME REV. ROBT. FRANKLIN THOMAS

14. MOTHER'S MAIDEN NAME MARY E. ADAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. ?

17. INFORMANT Address RD #1 MRS. MARY E. THOMAS, NEW WINDSOR, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH One hour
DUE TO (b) Chronic Alcoholism 3 years
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 322.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/14, 1956, to 9/14, 1956, that I last saw the deceased alive on 9/19, 1956, and that death occurred at 8:19 M, from the causes and on the date stated above.

ACTUAL SIGNATURE S. Luther Bare M.D. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 9/19/56

PHYSICIAN'S NAME (Type) S. LUTHER BARE

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF SEPT. 21, 56

22c. NAME OF CEMETERY OR CREMATORY WESTERN CHAPEL

22d. LOCATION (City, town, or county) (State) RURAL, WESTMINSTER, Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. ADDRESS WESTMINSTER Md.

24a. REC'D BY REGISTRAR DATE 9-21-56

24b. REGISTRAR'S SIGNATURE Harriet Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09231

9239

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b: 15 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WIMERT NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS: R. D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle GUILFORD — Last VEITCH

4. DATE OF DEATH: Month SEPT. — Day 26 — Year 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 5-5-1869

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POLICE RET.

10b. KIND OF BUSINESS OR INDUSTRY: BALTO. CITY

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS L. VEITCH

14. MOTHER'S MAIDEN NAME: GERTRUDE WOOD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: SAMUEL L. VEITCH — Address 1463 MANOA RD. DEMAN WINNIE, PHILA, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis (chr), Nephritis (chr) — INTERVAL BETWEEN ONSET AND DEATH
542X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1952, to Sept 26, 1956, that I last saw the deceased alive on Sept 25, 1956, and that death occurred at 7 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Jennette, M.D. — ADDRESS (Street, city or town, state): 103 E Main — DATE SIGNED

PHYSICIAN'S NAME (Type): Wm Carl Jennette — Westminster Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 1, 1956
22c. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE CEMI.
22d. LOCATION (City, town, or county) (State): PIKESVILLE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: H BANNARD YSON — ADDRESS: WESTMINSTER, MD.

24a. REC'D BY REGISTRAR DATE: 9-26-56

24b. REGISTRAR'S SIGNATURE: Hazel Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09232

9240

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Mills

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Meadow View Nursing Home

d. STREET ADDRESS: 43 Carroll St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Harman Last: Wardenfelt

4. DATE OF DEATH: Month: Sept. Day: 10 Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1878

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry Wardenfelt

14. MOTHER'S MAIDEN NAME: Elizabeth Frizzell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): — — — —

16. SOCIAL SECURITY NO.: 214-28-5340

17. INFORMANT: Charles E. Wardenfelt Address: Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myasthenia Gravis — INTERVAL BETWEEN ONSET AND DEATH: 1 year.
DUE TO (b): —
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

744.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 2, 19 53, to Sept 10, 19 56, that I last saw the deceased alive on Sept 10, 19 56, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Julius Chepko M.D.

ADDRESS (Street, city or town, state): 85½ W. Green St. Westminster, Maryland

DATE SIGNED: 9/10/56

PHYSICIAN'S NAME (Type): Julius Chepko

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-12-56

22c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

22d. LOCATION (City, town, or county) (State): Smallwood, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Byers ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 9-12-56

24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09233

9241 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3701-4

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 19 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wasososki. Middle WASOCKI Last Milton
4. DATE OF DEATH: Month Sept. Day 23 Year 19 56

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: unknown
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service): u
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediately
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis cerebral arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1 1950, to Sept 23, 1956 that I last saw the deceased alive on Sept. 22, 1956, and that death occurred at 7 30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt, M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 9/23/56
PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 26/56
22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Mary
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W Ozaganski ADDRESS: 1930 Eastern
24a. RECD BY REGISTRAR DATE: SEP 26 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Harp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9242 09234

Items 8,9: G204 10-2-56:L

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 27 days, 3 mos. 44 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: Florence; Middle: Woods; Last: Weidman

4. DATE OF DEATH: Month: September; Day: 26; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1875/ 1870

9. AGE (In years last birthday): 86 81 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jeremiah Woods

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Springfield Hospital records — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Multiple lung abscesses — unknown

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dementia Praecox - paranoid type of long standing

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to September 26 1956, that I last saw the deceased alive on September 26, 1956, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/26/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept 29/1956 — 22c. NAME OF CEMETERY OR CREMATORY: London Park — 22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Harry Wannacott — ADDRESS: 4204 Ridgewood Ave

24a. REC'D BY REGISTRAR — DATE: SEP 28 1956

24b. REGISTRAR'S SIGNATURE: C. Harry Weers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9243 **CERTIFICATE OF DEATH** 09235 Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Carrol — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: Since 6-16-55
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Baltimore City 311
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3V01.4
d. STREET ADDRESS: 3521 Kentucky Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN — Middle GERTRUDE — Last WELLEMIN
4. DATE OF DEATH: Month SEPTEMBER — Day 8 — Year 1956
5. SEX: Fe
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 15,1892
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months 6 — Days 24 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Raised foster children
10b. KIND OF BUSINESS OR INDUSTRY: Foster mother care
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Overman
14. MOTHER'S MAIDEN NAME: Catherine Behrens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): Nil
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Daughter: — Address: Mrs. Sylvia Gehrig -3521 Kentucky Ave., Balto 13, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b): ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC BRAIN SYNDROME ASSOCIATED WITH ARTERIOSCLEROSIS WITH PSYCHOSIS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 15, 1955, to September 8, 1956, that I last saw the deceased alive on September 8, 1956, and that death occurred at 4:45A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Valdis Aizkrauklis M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/8/56
PHYSICIAN'S NAME (Type): VALDIS AIZKRAUKLIS, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-11-56
22c. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ulrich Funeral Home
ADDRESS: Belair & Bells. Md.
24a. REC'D BY REGISTRAR DATE: 9-8-56
24b. REGISTRAR'S SIGNATURE: C. Haney Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9245

CERTIFICATE OF DEATH

09237

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 829 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 736 George Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen; Middle: Lenora; Last: Williams

4. DATE OF DEATH: Month: 9; Day: 16; Year: 1956

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep

8. DATE OF BIRTH: 3-19-1905

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Drew

14. MOTHER'S MAIDEN NAME: Evera Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-28-2580

17. INFORMANT: Patient, Helen L. Williams
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Far advanced bilateral cavitary tuberculosis
002 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1954, to Sept. 16, 1956, that I last saw the deceased alive on Sept. 16, 1956, and that death occurred at 6.00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal M.D.
ADDRESS (Street, city or town, state): Henryton, Md.
DATE SIGNED:

PHYSICIAN'S NAME (Type): T. F. Vestal
Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/19/56
22c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles S. Cooper
ADDRESS:

24a. REC'D BY REGISTRAR DATE: 9-16-56
24b. REGISTRAR'S SIGNATURE: Albert R. Swanklens

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09239

9244

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
c. LENGTH OF STAY IN 1b: 54yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 29 Fair St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster, Md.
d. STREET ADDRESS: 29 Fair St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALVERTA Middle JANE Last NICKS

4. DATE OF DEATH: Month Sept. Day 29 Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 24. 1889
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None - wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Louisville Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Conaway
14. MOTHER'S MAIDEN NAME: Katherine Schaeffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT (Address): M. Chas. W. Wicks, Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occl. Stenosis — INTERVAL BETWEEN ONSET AND DEATH: Apx - 5 hr
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): + Infarction of
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apx, 19 56, to Sept 28, 19 56, that I last saw the deceased alive on Sept 28, 19 56, and that death occurred at 1.58 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Jarnette M.D. ADDRESS (Street, city or town, state): Westminster Md DATE SIGNED: 9-29-56

PHYSICIAN'S NAME (Type): Wm Carl Jarnette 103 E Main

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 1, 56
22c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery
22d. LOCATION (City, town, or county) (State): Smallwood Carroll Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, Jr. ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 9-30-56
24b. REGISTRAR'S SIGNATURE: Hamet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9193

CERTIFICATE OF DEATH

09238

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: COLLEGE HILL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD.
b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS: COLLEGE HILL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LOLA Middle MAY Last WOOD

4. DATE OF DEATH: Month SEPT. Day 28 Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-15-1864

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ZACHARY TAYLOR WOOD

14. MOTHER'S MAIDEN NAME: LOLA MACUBIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: LOTTIE MAY GREIMAN Address COLLEGE HILL WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332X Cerebral softening
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH
2+ yrs
4+ yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Valvular heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ~~Jan 6, 19~~ to Sept 28 1956, that I last saw the deceased alive on July 12 1956, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Reese Wilkens M.D. ADDRESS (Street, city or town, state): Kemp Ave Westminster Md DATE SIGNED: 9/29/56

PHYSICIAN'S NAME (Type): E. REESE Wilkens

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-2-1956

22c. NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH Cem.

22d. LOCATION (City, town, or county) (State): WESTMINSTER, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: H Bankard Son ADDRESS: Westminster Md.

24a. REC'D BY REGISTRAR DATE: 10-3-56

24b. REGISTRAR'S SIGNATURE: Hannah Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9246

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1932 N. Patterson Park Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: — Last: ZUEBERT

4. DATE OF DEATH: Month: September — Day: 20 — Year: 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 80 ? yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown U.S.C.A.R.
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown John Zuebert
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Springfield Hospital records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular dis. — INTERVAL BETWEEN ONSET AND DEATH: Years.
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis. — Years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with arteriosclerosis.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 14 1956, to September 20 1956, that I last saw the deceased alive on September 20, 1956, and that death occurred at 3:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/20/56

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 24th 56
22c. NAME OF CEMETERY OR CREMATORY: Mt Carmel Cem
22d. LOCATION (City, town, or county) (State): Donnell St Ext

23. FUNERAL DIRECTOR'S SIGNATURE: Leo G. Brooks — ADDRESS: 1201-03 N Patterson Park Ave
24a. REC'D BY REGISTRAR DATE: Sept 24th 1956
24b. REGISTRAR'S SIGNATURE: E J Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55